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Southern Nations Nationalities and People's Regional State Health Bureau

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Field Note
Sanitation and Hygiene Series

From Burden to Communal Responsibility

A Sanitation Success Story from Southern Region in Ethiopia

This is a sanitation success story from the Southern Region of Ethiopia where 20 percent of the country's population reside in 10 percent of a geographic area known for its high population density and ethnic diversity. The story explains how the Regional Health Bureau decided to focus on preventable diseases and how it then facilitated a strong region-wide commitment to high impact, public health interventions through the empowerment of households resulting in a wave of household latrine building.

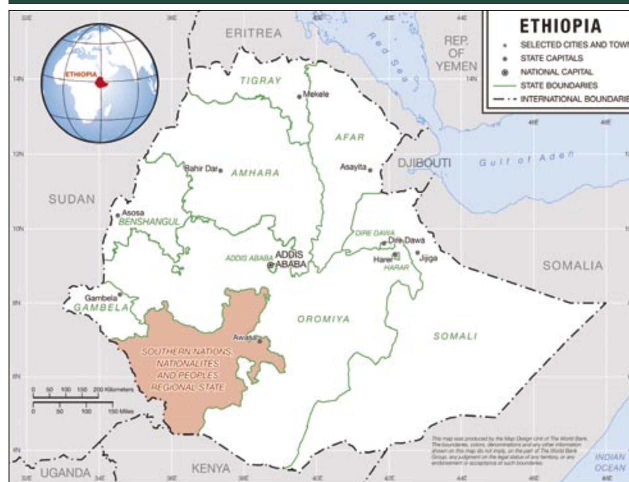
Summary

This is a sanitation success story from the Southern Region of Ethiopia where 20 percent of the country's population reside in 10 percent of a geographic area known for its high population density and ethnic diversity. The story explains how the Regional Health Bureau decided to focus on preventable diseases and how it then facilitated a strong region-wide commitment to high-impact, public health interventions through empowering households, resulting in a wave of household latrine building.

This sanitation story is distinctive because it was successfully driven by the Health Bureau (working closely with all key stakeholders), using their own funds through a cascading process of advocacy, consensus (and capacity) building, promotion (via community volunteers) and supportive supervision. Alongside other gains in public health, pit latrine ownership rose from under 13 percent in September 2003 to over 50 percent in August 2004. By August 2005, it had reached 78 percent, and a year later, was on-track to reach 88 percent. The Health Bureau is now working with Unicef, the African Development Bank, the European Union, the Water and Sanitation Program-Africa and the World Bank to empower households to upgrade traditional pits with permanent platforms and shelters, and to improve overall domestic hygiene.

As Dr Shiferaw Teklemariam, head of the Regional Health Bureau, points out: "... none of these achievements would have been possible without close inter-sectoral collaboration and strong leadership, committed to universal Water Supply and Sanitation (WASH) access. This collaboration has been further strengthened by both national and regional memoranda of understanding which will formalize sector synergy and build on the universal coverage approach of the health service extension program. This is the positive and sustainable foundation from which to follow the roadmaps and achieve our MDGs".

Map of Ethiopia



Background

For a long time, Ethiopia has featured at the bottom of the international league table of access to 'on-site' sanitation - estimated at less than 18 percent in 2002/3. This figure reflects considerable regional as well as rural-urban variation compounded by the usual difficulties in defining what constitutes an adequate 'on-site' sanitation option. Where success stories are reported, they have almost exclusively been facilitated by donor funding or NGO execution. The broad impression in Ethiopia is that population demand for 'on-site-sanitation' as well as government willingness to commit resources is low.

However, a number of regional success stories are emerging and one region in particular has demonstrated how well-placed donor support, combined with committed leadership and innovative low-cost approaches, can bring about a dramatic shift in household latrine construction. This field note describes the Southern Region's (Southern Nations, Nationalities and Peoples' Regional State) rise to the top of the domestic 'on-site' sanitation league table in the span of three years, and how several sanitation prejudices were overcome along the way.

The Southern Region is home to diverse cultures and scores of ethnic groups, with a population of 15 million - much bigger than many African countries. There are

13 zones and eight special *woredas*[1] – sub-divisions of a zone. In total, there are 133 *woredas* (districts) in the region. Some of the densely populated areas such as Wanago *woreda* in Gedeo zone are inhabited by 1,100 people per square kilometre, while peripheral areas such as South Omo and Bench Maji have low population densities. In early 2003, access to 'on-site' sanitation was estimated to be under 13 percent - even lower than the estimated national average of 15 percent.

From under 13 percent to more than 77 percent in two years

In just two years, the region experienced a rapid improvement. As Dr Shiferaw reported to the press in February 2005: "Walk into any household in Southern Region and you have a three in four chance of finding a pit latrine, and this does not include the latrines that haven't been counted for quality reasons."

The Regional Health Bureau head explained how they had shifted from the broad primary health care model to focus on a limited number of 'high impact, broad reach, low cost' public health interventions. Recent supervision and monitoring has revealed that public interest in and adoption of latrines, immunization, and family health, is set to rise above the critical threshold of

Dr. Shiferaw and Kebele (village) Chairman

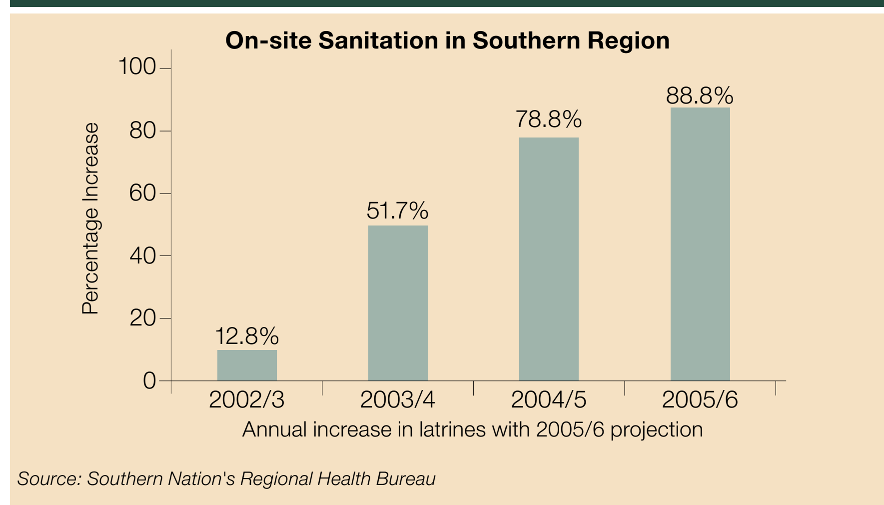
80 percent in the space of three years. He suggested the key to this success was a combination of consensus and commitment from the household to the regional assembly. As one environmental health official remarked: "We are all infected with the same enthusiasm and talking with the same voice..."

Drivers of Adoption

At the household level, women have been identified as the main drivers of latrine construction. At public consensus-building meetings, they complained about how open field defecation directly affects their lives. They highlighted the health risks of contact with feces in the banana plantations, and in the fields where they collect fodder for cattle. They also complained of the bad smell and embarrassment of seeing people defecate in the open[2].

At the village level, volunteer community health promoters have led by example and gone house to house with health extension workers and members of the *kebelle*[3] health committee to persuade householders to follow suit. At health center and *woreda* level, environmental health workers, working under the supervision of the *woreda* health

Figure 1. Latrine Construction 2002/3 to 2005/6[4]



Source: Southern Nation's Regional Health Bureau

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[1] Special *woredas* were created to protect the interests of concentrations of distinct ethnic groups providing them with their own administration

[2] In line with the Southern experience, the Community led Total Sanitation approach in Bangladesh identified 'self-respect' as one of the main motivating forces behind latrine construction (see footnote 4)

[3] *Kebelle* is the Amharic word for sub-district (a collection of villages containing as many as 2000 households)

[4] The years 2003-2006 are 1995-1998 in the Ethiopian Calendar

office (with inter-sectoral and political support), provided training, technical direction and encouragement.

The zonal level has also provided an important intermediary level in driving the process as emphasised by the story in Box 1, where shame was cited as an important factor in consensus-building and a strong motivator for latrine construction. At the regional level, the Health Bureau has been the prime driver with the support of the regional cabinet. In this context, the official ratification of the Regional Public Health Proclamation in August 2003 and the processes followed in the formulation of the regulation, were key drivers in attracting political support and commitment.

Determining Factors

In order to achieve a social change of this magnitude, it is widely accepted that five key factors must be in place: well-informed, well-respected, well-connected leadership; an affordable product; latent demand by a critical mass of early adopters; the right context; and the 'tipping point'. An

Final steps in constructing a latrine

analysis of the prevailing situation in Southern Region reveals a high level of fulfilment of these criteria.

Leadership

Throughout the health hierarchy in Ethiopia, there is no shortage of inspired, well-informed and committed leadership but in Southern Region there has been an exceptional willingness to take risks and challenge conventional primary health care approaches. This has included making a modest but dedicated sum of money available for the mass mobilization of the entire population as sanitation stakeholders under the slogan: 'Sanitation is Everyone's Problem and Everyone's Responsibility'.

An affordable product

The Southern Regional Health Bureau has applied some of the key guiding principles of the highly acclaimed Community-Led Total Sanitation (CLTS) approach[4] – that of 'zero subsidy' – but allowing the community to come up with its own innovative and affordable models. The CLTS approach has contributed to a similar dramatic latrine coverage improvement in South Asia. In Bangladesh, where the approach was pioneered, sanitation coverage has improved from around 30 percent in 2004 to over 70 percent today[5]. In India, Maharashtra State has scaled up to 3,500 local governments claiming 'defecation free' status in three years.

Latent demand

In the limited Knowledge, Attitude, Belief and Practice studies[6] carried out in Ethiopia, women expressed demand for a safe, private, hygienic, smell-free latrine while men acknowledged the importance of a latrine, particularly during the rainy season. However, latrine construction has not generally been prioritized. In Southern Region, women volunteer community health promoters have became the influential, early adopters supported by leaders at all levels.

Box 1: 'Shame' – A Key Driver

Dr Shiferaw explained that during the cascading advocacy and consensus building process, a zonal administrator was asked if he would stay in a village overnight. His hosts were embarrassed when the administrator asked, "but what happens if I need a latrine?" The zonal administrator noted and reported on the obvious shame his question had caused and how rapidly consensus was reached on the need for latrine construction. He was later gratified to be invited a second time by the same village, but this time without the faintest hint of embarrassment as the whole village had built latrines.

Dr Shiferaw added that shame over the prevailing sanitation situation, and dismay at the poor progress of programs and projects to effect change, had been important drivers of change both within his department and the regional cabinet.

Source: Interview with Dr Shiferaw, 04/05/06

[4] Kar K. (2005) *Subsidy or self-respect. Community Led Total Sanitation: an update*. IDS Bulletin 257

[5] Bangladesh Bureau of Statistics, Unicef Courtesy of WSP Bangladesh (2006)

[6] WaterAid (2003) *KABP study on defaecation and latrine preference*

The right context

Traditional sanitation wisdom suggests that where houses are scattered and there is a wide choice of rocks, bushes, trees and gullies to provide privacy, then demand for latrines is limited. In Southern Region, population expansion resulting in high household densities, and deforestation have combined to reduce private open defecation options. In addition, girl-child school enrolment in, and completion of, primary and secondary schools is significantly above the national average. The Health Bureau leadership suggest that women in Southern Region have been better able to express their sanitation priorities and influence their husbands. An additional important contextual factor has been the long-term partnership with John Snow International through the USAID-funded project, Essential Services for Health in Ethiopia. This partnership gave greater emphasis to 'high impact' public health programs and sponsored the training of community health promoters who not only led by positive example but went door-to-door, to successfully persuade households to follow suit.

Table 1. Latrine building by Zone/Special *Woreda* in Southern Region 2002/3 - 2003/4

No	Zone or Special Woreda	Latrine Coverage%		% Increase	Population (2005)	Households
	Zones	**2002/3**	**2003/4**			
1	Benchi Maji	9	72	63	449,521	89,904
2	Dawro	15	41	26	367,726	73,545
3	Gamo Goffa	16	60	44	1,467,974	293,595
4	Gedeo	15	54	39	773,164	154,633
5	Gurage	14	96	82	1,533,279	306,656
6	Hadiya	13	49	36	1,298,736	259,747
7	Kaffa	11	38	27	789,818	157,964
8	Kembatta-Tembaro	18	72	54	706,525	141,305
9	Shaka	9	60	51	181,508	36,302
10	Sidama	18	62	44	2,775,532	555,106
11	Silti	7	40	33	774,559	154,912
12	Southern Omo	10	36	26	447,084	89,417
13	Welayta	14	57	43	1,582,469	316,494
	Special Woredas					
14	Alaba	10	48	38	204,254	40,851
15	Amaro	12	65	63	132,326	26,465
16	Basketto	6	16	10	43,324	8,665
17	Burji	12	31	19	53,095	10,619
18	Derhashe	9	75	66	122,272	24,514
19	Konso	11	14	3	212,272	42,454
20	Konta	8	54	46	82,255	16,451
21	Yom	31	46	15	87,009	174,018
	Region	**12.8%**	**51.7%**	**39%**	**14,084,702**	**2,973,617**

A typical traditional village setting

The pilot *woredas* demonstrated what could be achieved; it was now up to the regional government to take it to scale.

The tipping point

Referring to the prevailing health situation prior to 2004, Dr Shiferaw described a phenomenon known as the ‘leaking bucket’ effect: “The rural people get sick, they are treated and leave, then they get sick again, are treated again....and the cycle continues. They spend most of their cash income on health care.”

With support from John Snow International, the regional health leadership was starting to recognize the value of improving prevention but the actual trigger for change came from an unlikely source.

It was one of the Bureau drivers who overheard a senior health manager state that 80 percent of the disease burden in the region was preventable. The driver remarked that the same assertion had been repeated for the last ten years and, with a mixture of guile and ill-concealed skepticism, suggested that surely after a decade some of the diseases might actually have been prevented! This story illustrates another important factor in the success story – that of the willingness of senior management to listen to the people and to put the people first.

Steps to Sanitation Improvement in Southern Region

STEP 1: Pilot

The high-impact approach was piloted in 20 *woredas* selected on the basis of the community's willingness to dig latrines. The most successful of these was Misha *woreda* located in the more densely populated, rolling hills of the North East zone of Southern Region. It now boasts over 75 percent latrine coverage - an increase of more than five times the baseline figure (with reported increased handwashing after latrine use); more than 85 percent immunization and 60 percent family

planning use. The pilot process, although externally supported by USAID funds and with technical input from John Snow International, was designed to operate within a framework that could be replicated by government. The key factor was that the framework could be scaled up and implemented within the regional public health budget.

STEP 2: The ignition documents

On the basis of results from the pilot and in line with the new health policy in Ethiopia, the Regional Health Bureau decided to shift their health focus and increase time and money spent on preventing morbidity. The regional government produced a series of 'ignition' documents' (Health Development Popular Mobilisation) in 2003/4. The ignition documents were used to stimulate discussion among regional, *woreda* and zonal staff about the prevailing burden of disease and the various contributing factors.

A list of 20 causes of outpatient morbidity and mortality were identified by the health teams and the underlying factors to these problems were found to be: communities' low awareness on health, low coverage of health services, and the high prevalence of easily preventable diseases. The ignition documents outlined how to intervene in various high impact health areas by shifting from a curative to a preventive focus.

The six key interventions were:
1. Household pit latrine construction
2. Vaccinations – DPT 3
3. Creating health posts
4. Maternal and childcare
5. Family planning
6. Strengthening Outpatient Service Delivery (focus Malaria and HIV/AIDS)

Box 2: It all started in Misha...

"It is August, the countryside is greened by the ample rains and the observer, eager for clues to explain the success, notes that this is not the home of the 60 percent of Ethiopians depending on food-aid; market day in Misha *woreda* suggests good times. The skeptical observer notes that the context is right. The locally-based religious mission with a strong focus on education has ensured that the majority of farmers reach level 12 (completing high school but not necessarily passing college entrance exam) and current girl school enrolment is at 89.2 percent, a stark difference from the national average of 50.6 percent.

Up to 2005, Southern Region had an unusual structure in that both the health and education desks were coordinated by a capacity building cadre at all levels which was designed to encourage closer inter-sectoral collaboration, co-ordination and mutual reinforcement. The current *woreda* health team greets us, cheerfully explaining that the team's full complement should be 17! The team consists of three members: the health desk head, an environmental health officer responsible for disease prevention and control and a mother-and-child health nurse. Although they are assisted by professionals from health posts, health centers and two NGO clinics, they repeatedly emphasize the importance of community health promoters. The team explain the morbidity data displayed on the walls of their cramped office, emphasizing a spectacular epidemiological shift. Reported diarrhea (gastric infections), helminths and eye/skin infections have progressively fallen out of the top five infections during the last four years. The team is rightly proud of their achievements.

The methods have been diverse. They actually demonstrate active amoebic protozoa as an advocacy tool. They engage influential leaders in the laboratory analysis of stools to demonstrate how bacteria and protozoa could enter the body through poor sanitation and hygiene. The team have employed drama and role-playing effectively at different ceremonies to raise important public health issues, emphasizing over and over again that prevention starts in the home and not at the health post, the *woreda* health office or the Regional Health Bureau in Awassa.

Even though the visiting team is three hours late and it is the end of the day, we are joined by other *woreda* desk officers who have returned specially for discussions and sit for three hours explaining what they see as keys to their success. They emphasize leadership, teamwork and personal commitment. Even without the benefit of Amharic, the observer notes that here is a team, working in concert, eager to complement each other's work and share the burden as well as the spoils of their considerable achievements. As we are waved on our way, the team point to a brand new Toyota Land Cruiser parked outside – a collective reward for their efforts. Misha *woreda:* 'Best in Zone' and 'Best in Region'.

Source: The Water and Sanitation Programme team – field visit report extract

STEP 3: Dedicated finance

In 2002/3 pit latrine coverage was under 13 percent. The following year it rose to more than 50 percent, and in 2004/5 reached 78 percent. "The number of latrines rose from around 100,000 to 2 million," says Dr Shiferaw. People did this at their own expense. The activities which were funded (detailed in Box 3) did not cost more than 500,000 birr (around US$50,000). The target for 2005/6 is to attain 90 percent coverage but with close quality assurance to a 'minimum safety/hygiene standard' (this includes being more than 20 meters from a water source and 'down-wind' of people's dwellings).

STEP 4: Cascading advocacy and consensus building

The ignition documents were discussed by regional experts, zonal health officials and capacity-building staff at zonal and *woreda* levels to reach consensus on the need for the six high-impact interventions. The regional government encouraged zonal and *woreda* officials to talk to the *kebelle* – smaller, local administrations – on ways to involve the community and ensure there was political will to back their actions.

While politicians and civil servants spoke with one voice, leaders at all levels were rallying their people to create a positive social epidemic. "We wanted to involve the people," says Dr Shiferaw, "because in the past people thought sanitation should be done by government and NGOs. One had to be a health official to get involved in such things. What we have achieved could only have been done with the participation of the people."

Table 2. Sample of a Performance Contractual Agreement

Zone/ special *woreda* ....

Woreda ....

	Latrines	Immunisation DP3	Health Post Construction	MCH Service Coverage	Family Planning Service Coverage	Outpatient Service Delivery incl. Malaria
Target	%	%	%	%	%	%
Achieved	%	%	%	%	%	%

Signed *Woreda* ....

Signed Zone ....

Signed Region ....

STEP 5: Appropriate technology

The Regional Health Bureau set minimal standards for latrine construction, preferring to follow the Community-Led Total Sanitation approach where the central objective is to break the culture of open defecation while allowing the community to choose how to achieve it.

The Regional Health Bureau set some criteria for construction as follows:

1. Site:
   - 20m-30m from water source
   - Wind direction away from dwellings
   - At the back of dwelling
2. Pit design:
   - Stable soil type – rectangular
   - Unstable soil type - circular
3. Platform (floor slab):
   - Should cover the pit
   - Should slant towards the hole
4. Superstructure should consist of roof and walls
5. Should be provided with diversion ditch to protect the pit from flooding
6. Should be provided with hand washing facility

Box 3: Funded Activities

1. Preparation of community mobilization document
2. Per diem for meetings to discuss the prepared document
3. Trainer of Trainers for health professionals
4. Training for health promoters and supportive supervision

Source: Regional Health Bureau

Currently, the Regional Health Bureau is engaged in intensive capacity building activities throughout its structures, with a strong focus on promoting conformity with sustainable technical standards. The Bureau acknowledges the importance of use as well as access and quality and is currently planning to conduct a study to assess how many of the latrines conform to the technical criteria and what behavior change has taken place in terms of family latrine use and hand washing frequency.

STEP 6: Performance-related agreements

Southern Region government officials have introduced a performance contractual agreement that covers all six of the high-impact interventions. It is a method to encourage results-oriented management and make sure that the officials (politicians and civil servants) at various levels agree to achieve and actually deliver key public health targets. The agreement has a simple format which details the 'high impact' targets

for the *woreda*, zone and region. At the village level, community-based leaders sign similar agreements with *woreda* officials to facilitate implementation of agreed targets at the *kebelle* level.

This is part of the on-going Civil Service Reform for results-oriented performance appraisal. The contract sets a minimum acceptable level of delivery with incentives for the three best performing *woredas* - the top prize being a vehicle.

STEP 7: Training (community health promoters) with supportive supervision

During the pilot phase, with assistance from John Snow International, *woreda* Trainers of Trainers were selected and trained on the 'minimum health package.' They in turn facilitated the selection and training of community health promoters on the 'minimum health package'. This process has now been replicated in all other *woredas*.

One community health promoter has been chosen for every 30/40 households and charged with mobilizing the people towards fulfilling the high impact objectives. They are unpaid although the community is expected to assist them with farming activities. They are expected to volunteer in their spare time, when collecting wood and water with other village members and during events such as coffee ceremonies, weddings and funerals.

There is general agreement that volunteer community health promoters have been one of the most important factors in encouraging latrine construction and use. They have mobilized the community to change behavior by encouraging the adoption of small doable actions. It is these volunteers with minimal training who have provided the essential health link between *woreda*, *kebelle*, sub-*kebelle*, village and household. They have been well supported by elected leaders, as well as traditional and religious leaders, and personnel from health and other sectors. The essence of success here can be attributed to teamwork.

Health extension worker training community health promoters

Community Health Promoters demonstrate latrine construction in their own households and offer advice to their selected 30/40 households on construction. Those unable to dig their own pits, such as the sick and elderly, receive help from others. A clear hierarchy of responsibility – from the region, to the zone, to the *woreda,* to the health unit, to the *kebelle,* to the health extension worker, to the community health promoter, and ultimately to the household – have been crucial elements in the overall success of the high-impact public health interventions.

STEP 8: Monitoring and evaluation

The Region is currently working to develop cascading monitoring and evaluation systems to link with the national health information management system but the cascading performance-related contracts have provided an important means of monitoring as well as ensuring accountability. In addition, an independent household survey (conducted by the Kale Hiwot Church[7]) as well as routine monitoring by other bilateral organisations[8], confirm the reported 2004/5 latrine coverage figures.

[7] In 2005, the Kale Hiwot Church carried out an independent household study covering a number of *woredas* to submit a funding proposal to UNICEF. The *woreda* latrine coverage (complying with a minimum standard) ranged from 17 percent - 59 percent.

[8] Unicef has been working in 43 *woredas* and their assessment of those households with latrines fulfilling a minimum standard up to 2005 is 50 percent *Source: Therese Dooley – Unicef Hygiene and Sanitation specialist*

An important strength of the Southern Region's approach has been the consensus-building framework and the willingness of cabinet members to participate in the annual situation analysis process leading to the preparation of strategic plans. In this way, politicians experience first hand what the problems are and whether the planned activities are having any impact. They play an important motivating and monitoring role.

As the Regional Health Bureau suggests, it is too early to expect substantive changes in morbidity patterns, although the pilot *woredas* – with their advanced broader hygiene success – report reduced diarrhea and worm infestation at health centers. In addition, while construction figures have been rigorously collected and cross-checked (with some construction discounted due to poor quality), they suggest that only half the latrines constructed are actually used[9].

Improved hygiene through handwashing

Anecdotal reports from women during field visits indicate reduced smell and reduced contamination of the 'false' banana plantations and the fields where they collect animal fodder. However, besides the actual use of latrines, other factors such as safety, durability, privacy and hygiene of already-constructed latrines present real challenges for the future. In addition, comprehensive approaches to improve handwashing and the safe drinking water chain are only just beginning.

The Way Forward

While Dr Shiferaw and his colleagues are recognized for facilitating the sanitation epidemic, the regional staff are under no illusions about the uphill struggle they face. The majority of households have dug traditional latrine pits with a wide variety of platforms and super-structures of an essentially temporary nature. Children or animals falling into pits, pits overflowing, roofs caving in and bad smells, all combine to give traditional pit latrines a bad name, resulting in low usage.

The first challenge is to build on the existing momentum and turn these pits into durable, appropriate and affordable latrines that can be used by the whole family. The second will be to focus on urban areas that are lagging behind. The third challenge is to improve hygiene, particularly handwashing at critical times but also water safety and food hygiene.

The regional government recognizes that it cannot take sanitation to the next level without additional support. They have therefore been developing further partnerships – with donors, NGOs, the private sector and the people – to make a range of affordable technical options and hygiene consumables more available at the local level. Through national government programs supported by the World Bank, the African Development Bank and Unicef, all 133 *woredas* in the region will have additional resources. Bridging the technology gap is recognized as a major challenge and the Water and Sanitation Program will expand its regional support to include a study to assess the local sanitation market.

Box 4: Community Health Promoters

Selection criteria for community health promoters:

- Volunteer, committed and motivated
- Acceptable by the community
- Able to read and write
- Shows exemplary behavior

Their only incentives are:

- Can join Health Extension Worker training (upgrading skills)
- Are paid per diems during campaigns (e.g. national vaccination campaigns) and receive T-shirts
- In some cases they are provided support for their farming activities during the time they are doing voluntary work
- Recognition from the community as 'health information resource person'

Source: Regional health bureau

[9] In baseline health surveys conducted in 2003 by the Health Bureau, latrine ownership and use was reported to be 35 percent
Source: MoH, USAID, ESHE(2005) - Twelve Baseline Health Surveys

Health extension worker visiting a household

The Region, as an important contributor and supporter of the National Hygiene and Sanitation Strategy and Protocol, will not provide individual household subsidies (with exceptions for groups with special needs) but will invest in creating an enabling environment.

Activities already identified will include extensive software (including participatory hygiene and sanitation transformation skills and tools), artisan training (and equipping), the establishment of sanitary outlets, demonstration units (at the homes of community health promoters and food distributors) and institutional latrine construction, particularly at schools.

While some of the new latrines have some form of hand washing facility, the regional team acknowledge the challenge of ensuring that all latrines, whether household, communal or institutional, have hand washing stations. To achieve such important behavior change functions, 15 NGOs have been charged with responsibility for facilitating participatory hygiene and sanitation transformation skills learning by *woreda* health staff, health extension workers and community health promoters.

In summing up this success story, Dr Shiferaw is quick to re-emphasize the central role played by the people. He suggests that the Region has experienced a cultural revolution which has made latrine ownership the rule, not the exception. While he accepts that he and his team have played an important facilitating role, such a rapid social change could only have been achieved with the participation of the people. “Sanitation is not something you give away as a commodity,” he points out.

Dr Shiferaw and his team are now engaged with the challenge of making sure latrines are safely used by all members of the family, and that handwashing is done at the four[10] critical times so that, like latrine ownership, the practise becomes the rule rather than the exception.

[10]The four critical times are: after defaecation, after cleaning a child’s bottom, before preparing food and before eating food.

About the Sanitation and Hygiene Series

WSP Field Notes describe and analyze projects and activities in water and sanitation that provide lessons for sector leaders, administrators, and individuals tackling the water and sanitation challenges in urban and rural areas. The criteria for selection of stories included in this series are large-scale impact, demonstrable sustainability, good cost recovery, replicable conditions, and leadership.

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